Command Directed Report of Investigation on

Active Shooter Response

August 2, 2018

at Wright-Patterson AFB

Executive Summary

Cleared for Public Release

BACKGROUND:

During a scheduled week of exercises for Wright-Patterson Air Force Base (WPAFB), an installation-wide active shooter exercise was conducted on 2 August 2018. The exercise was conducted pursuant to Air Force requirements to hold an active shooter exercise twice a year.

The active shooter exercise was planned and executed by the 88th Air Base Wing Inspector General (88 ABW/IG) who also produced a Master Scenario Events List (MSEL). The active shooter exercise was conducted at the Kittyhawk Chapel with role players simulating casualties.

During roughly the same time period as the active shooter exercise, the 88th Medical Group (88 MDG) held an internal exercise at the WPAFB Medical Treatment Facility to test their mass casualty response procedures. This was intended to be a stand-alone exercise, not a branch of the installation active shooter exercise. This internal 88 MDG exercise was socialized with 88 ABW/IG, but not documented in the 88 ABW/IG published Master Scenario Events List (MSEL). The 88 MDG produced a stand-alone MSEL. There is no evidence of either the 88 ABW/IG or the 88 MDG conducting and documenting a formal risk assessment for either of the exercises.

During the course of the 88 MDG mass casualty exercise, confusion entered the exercise when a real world 911 call came in about a 88 MDG employee receiving a cell phone call from another 88 MDG employee, who was screaming and crying due to an injury received while running on WPAFB. The injured jogger was located and brought to the ER. This was the beginning of bleed over from exercise to real world events. Simulated casualties for the 88 MDG exercise were reporting at the same time as the real world injured jogger and at the same time first responders were responding to the active shooter exercise at the Chapel. At 1238, the Base Defense Operations Center received a direct call by landline from the military treatment facility of a real world active shooter event. The hospital staff also issued a "Code Silver" over the intercom that directed hospital personnel an active shooter was in progress and initiated a facility lockdown.

These actions led to on-base forces initiating a response to the hospital for what they now believed was a real world active shooter.

After hearing the "Code Silver," a 88 MDG employee in the hospital Red Clinic called 911 via cell phone which sends the call off-base to the 911 Call Center. This led to a "Code 99" or officer in distress call among civilian law enforcement agencies. The "Code 99" resulted in notification and activation of mutual aid responders from the Dayton area, the state of Ohio, and at the national level (FBI, ATF). The 88 ABW command and control structure did request mutual aid support in the form of a single Special Weapons and Tactics (SWAT) Team and three mutual aid medical units but were unaware of the Code 99 or civilian off-base active shooter protocols resulting in the mass response from off-base.

Mutual aid responders had challenges communicating with the Incident Commander (IC) because many of them did not initially precede to the entry control point or check in with the IC. Additionally, the IC was not immediately and readily identifiable. This added to the confusion for mutual aid responders who did try to check in. As a result of this fog and friction, the mutual aid responders quickly overwhelmed the IC's command and control capabilities. Mutual aid responders also reported communication difficulties, which they attributed to radio incompatibility between 88 ABW and local systems.

During the course of the response, 88th Security Forces Squadron (88 SFS) responders breached a locked door by firing rounds from an M-4 through the window of the door, causing additional 911 calls to be made from the hospital reporting a real world active shooter. The IC on-scene quickly learned it was 88 SFS personnel who fired the rounds. Despite the IC's attempt to explain the situation and otherwise stop them, approximately 50 area mutual responders bypassed the IC, breached the locked front door of the hospital, and entered with weapons drawn.

While responders were clearing the building, it became evident there was a gap between the Tactics, Techniques, and Procedures (TTPs) for clearing the building and the TTPs used by Airmen who worked in the facility. Specifically, after a team had entered a room and determined it was safe, they would announce "clear" to indicate to other responders the status of the room. Upon hearing the word "clear," employees hiding in adjacent rooms thought it was safe to come out and were met by responders with weapons drawn who were still sweeping through the building.

Ultimately the situation was resolved with minimal property damage and one minor injury to an 88 SFS Airman from the weapon discharge.

GENERAL FINDINGS:

This independent investigation made broad and wide-ranging recommendations for consideration that covered a multitude of areas. Some of these recommendations relate to the installation level and our internal exercise processes; others related to guidance at both the local and higher headquarters levels; and some addressed inter-operability between the installation and state and local responders.

Specific recommendations that directly relate to TTPs are considered For Official Use Only and not releasable to the public. However, we are able to release the following general findings that encapsulate the CDI results.

General Finding #1: The purpose of the MSEL is to ensure those directing the events know when every event will occur and can take preventive action to stop activities when they go off script. Having multiple exercises occurring in close proximity that were not on the MSEL created the conditions for confusion to occur. While realism is important in training exercises,

all personnel must be always be fully aware of exercise vs. real-world situations. Coordinating with all concerned organizations and then sticking with the agreed upon plan is essential to keeping everyone fully aware.

General Finding #2: An M-4 was used to breach a locked door that could not be opened with a key card. The Air Force Office of Special Investigation conducted a separate investigation on this specific action. The findings of this AFOSI report were referred to the member's commander to take appropriate action.

In addition to these findings, this CDI determined the use of this weapon in these circumstances was inappropriate. All personnel must adhere to weapons safety training at all times – especially during high pressure situations.

Furthermore, there needs to be a better process for Security Forces to identify themselves to personnel taking shelter. Air Force personnel are trained to "Run, Hide, Fight" while in shelter. If personnel follow this training, it is imperative they know how to identify friendly forces and when the "all clear" is given.

General Finding #3: A breakdown of communication led to a completely uncoordinated and ineffective combined response that could have resulted in serious injury or property damage. A thorough understanding between Federal, State and Local agencies about command and control to include understanding jurisdiction and response procedures needs to be established.